North Carolina Department of Health and Human Services

Michael F. Easley, Governor — Carmen Hooker Odom, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Mike Moseley, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-857-4011• Fax 919-733-6608
Mark T. Benton, Interim Director

MEMORANDUM

TO: Area Directors

FROM: Mike Moseley, Director, DMHDDSAS
Mark T. Benton, Interim Director, DMA MTB

SUBJECT: January through March, 2005 System Reform Issues Update

DATE: April 13, 2005

As we have previously pledged, our Divisions are committed to updating you quarterly on the status of various reform issues. We apologize that this update for the third quarter of SFY 2003-2005 has not been distributed on a timely basis. Outlined below are the key issues we are currently working on.

Update on State Plan Amendments and Waiver Requests

DHHS currently has three Medicaid State Plan amendments and two Home and Community Based Waiver requests pending approval with the Centers for Medicare and Medicaid Services (CMS). The three State Plan amendments relate to 1) changing the service rate setting methodology from cost settled rates to prospective rates and implementing the cost allocation for LME Systems Management payments (see next topic for additional information), 2) expanding the types of licensed outpatient therapists that may directly enroll with the Medicaid program and the age groups they may serve and 3) implementing the new service definitions and allowing direct enrollment of all providers of mental health, developmental disabilities and substance abuse services. The two waiver applications relate to a technical change to the existing waiver required by the April 1, 2005 implementation of the Piedmont Innovations waiver serving Cabarrus, Davidson, Rowan, Stanly and Union Counties and application for the new comprehensive CAP-MR/DD waiver projected to be implemented July 1, 2005. We anticipate that all of these amendments and waiver applications will be approved and we are moving forward quickly on training on all of them to ensure the system is prepared for the changes, but as we have noted in our earlier Updates, the anticipated implementation dates of all changes are subject to CMS approval.

Cost Allocation of LME Systems Management Payments

You may have read that CMS has raised some questions regarding the cost allocation of LME Systems Management payments. As you know, when we implemented the LME Systems Management payment process effective July 1, 2004 we also put in place a methodology for allocating a reasonable share of those costs to the Medicaid program. We had analyzed the impact on the Medicaid program to change from paying the "Area Program Administration 13%" of the service rates for Medicaid covered services and the cost allocation on the LME System Management payment and determined that the change would not have a significant impact on the total Medicaid expenditures for mental health, developmental disabilities and

substance abuse services. However, what we did not take into consideration in that analysis is the fact that DMA actually receives two (2) separate grants from the federal government for operation of the Medicaid program – one for administrative cost and one for services. As long as the "13%" was paid as part of the service rate, the funds actually out of the services grant. Under the new cost allocation claiming plan, those costs are reflected, accurately, as coming from the administrative cost grant award.

Because the LME Systems Management monthly cost reports for July and August were not received by the state until late September, the first time we actually claimed federal funds on those payments was in October, 2004. As a result, on the quarterly expenditure report that goes to CMS for the quarter ending December 31, 2004, there was a sharp increase in the claims against the administrative cost grant award. This caught CMS by surprise and they made the initial decision to "defer" funding (basically meaning they would withhold cash). A team from the Department made an emergency trip to Atlanta on March 8, 2005 to discuss the issue and, to our great relief, CMS understood our explanations and fairly quickly lifted the funds deferral. They are still going to look closely at the allocation methodology to satisfy themselves that Medicaid is covering no more than "its fair share" of LME Systems Management payments, but we feel confident that we can justify our actions and that this problem will go away. CMS is sending a fiscal expert to North Carolina the week of April 18, 2005 to conduct this review, so we will know more about where this issue stands later in the month.

Direct Enrollment of Licensed Clinicians Providing Outpatient Therapy

There has been a great deal of confusion regarding the providers who must enroll directly with the Division of Medical Assistance to provide outpatient therapy under the expansion of direct enrollment of Independent Practitioners. Effective January 1, all PhD Psychologists, Licensed Psychological Associates, Licensed Professional Counselors, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Psychiatric Clinical Nurse Specialist, Nurse Practitioners who are certified in psychiatric nursing or who are certified nurse practitioners in other fields and have *4 years experience in mental health nursing, Certified Clinical Supervisors and Certified Clinical Addiction Specialists who are independently employed or who are contract employees of other agencies were notified of the need to enroll Enrollment began February 1, however, this time frame was extended to March 1 for contract agencies of LME's **. These practitioners are enrolled to see all ages. Children's services continue to need a referral from the LME, a Carolina Access PCP or a Medicaid enrolled psychiatrist; adults do not need a referral. All practitioners will be reimbursed at their discipline rate.

***Note**: The following change is posted on the DMA website for comment: Nurse practitioners who are certified in another field with 2 years of experience will be enrolled under a sunset clause until 2010.

** (.** Note:** If you are an agency that employs these practitioners but also have a physician in the agency, enrollment will be required effective July 1, 05.

Phase II of this enrollment process will begin July 1,2005 and will include all of the above disciplines who are employees of the LME, the local health department, a school based health clinic, a physician's office or clinic and the hospital outpatient departments. An "incident to" provision will be allowed if you are employed by a physician, providing the services that would traditionally be provided in a physician office, the physician sees the client first and is actively involved in the care of the client. The physician must also be physically on site when the care is being provided.

On a related note, there has been some confusion regarding whether or not a LME can contract with a physician or other clinician without the physician having to directly enroll. If the LME has contracted with a physician under a personal services contract that means the contracted physician functions in a manner that is virtually identical to an employee, the LME may bill for the services provided by that physician just as they would for the services of an employed physician or other clinician. This should not be done as a means of by-passing the direct enrollment requirement, but may be done if the physician or other clinician basically doesn't have a practice for Medicaid eligible consumers outside their work with the LME. As part of Phase II implementation of outpatient therapist enrollment, when all LME clinical outpatient therapy staff is directly enrolled, the physician or other clinician under contract will have to be included.

Billing for Non-licensed and Provisionally Licensed Outpatient Therapists

There has been a great deal of concern expressed that the implementation of direct enrollment for licensed clinicians will negatively impact the ability to bill for non-licensed or provisionally licensed staff of provider agencies and Local Management Entities, since services delivered by those staff cannot be currently billed using CPT codes. With the implementation of the new service definitions there will be many services beyond outpatient therapy which these individuals will be qualified to deliver. At the current time, however, the opportunities for those individuals who are provisionally licensed to gain the necessary experience to become licensed are limited if they can no longer deliver outpatient therapy. More importantly, of course, is our knowledge that many consumers are receiving needed services delivered by these individuals.

We have agreed that for six months post-implementation of the new service definitions, unlicensed and provisionally licensed staff performing outpatient therapy may continue to be reimbursed through the LME by billing using the "H" codes. Provider agencies that are directly enrolled for all of their licensed staff will have to continue to contract with the LME in order to bill for their non-licensed or provisionally licensed staff. Effective with the implementation of direct enrollment of LME licensed outpatient therapists, we will be adjusting the "H" code rates to ensure that non-licensed and provisionally licensed staff are not reimbursed at a higher rate than licensed staff. More information will be forthcoming about this, but we wanted to be sure that the system understands that we will not act precipitously to eliminate billing by these categories of outpatient therapists.

Accrediting Bodies for Service Delivery

As you know, many of the proposed new service definitions require provider agencies to achieve accreditation by a nationally recognized accrediting agency within three (3) years of enrollment in the Medicaid Program. We have reviewed the policies and procedures of several national accrediting bodies and have approved the following organizations to meet this requirement:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Commission on Accreditation (COA)
- Council on Quality and Leadership (CQL)
- Council on Accreditation of Rehabilitation Facilities (CARF)

It is our intent that this list will be evolutionary and additional accrediting agencies may be added if their policies and procedures match the quality goals we are working to achieve.

Our Divisions have already agreed to add two additional accrediting agencies to the list of approved bodies for accreditation of LME functions. In addition to JCAHO, CARF, and NCQA (National Committee for Quality Assurance), we will also recognize COA and URAC (formerly the Utilization Review Accreditation Commission, Inc.).

As required by the DHHS/LME Performance Contract, if a LME is still providing services and the definitions for those services require national accreditation, the LME will have to achieve accreditation for both the LME functions and the services they provide. In those circumstances, we will only recognize accreditation from different bodies for the two parts of the organization. In other words, a LME whose LME functions are accredited by JCAHO would have to choose between COA, CQL, or CARF for its service accreditation.

LME Readiness to Perform Utilization Review for Medicaid Services

Eleven (11) LMEs indicated their preliminary interest in performing utilization review (UR) functions for Medicaid covered State Plan services effective July 1, 2005. We have evaluated those LMEs in relation to the criteria we outlined in our November 30, 2005 Update. We are on track to notify LMEs determined ready to perform UR functions for Medicaid State Plan service effective July 1, 2005 by May 1, 2005.

On the topic of UR, as most of you have probably already heard by this time, ValueOptions was the successful bidder on the RFP for statewide UR functions for mental health, developmental disabilities and substance abuse services. We are currently working with ValueOptions on issues related to the transition of this function effective July 1, 2005. We will be getting out much more information to you on this subject in the coming month.

Rates for New Services

We have completed the process of reviewing our proposed rates for new services – both the new enhanced services included in the State Plan Amendment as well as new CAP-MR/DD waiver services – and have had those rates approved by the DHHS Rate Review Board. The final rates are published on both Divisions' websites. We will not be making any more adjustments to these rates until we "go live" with the new services and providers actually have some experience in providing these services. After providers have some actual cost data, if there are adjustments needed in the rates we will be happy to entertain them at that time.

Thank you for all you are doing to help implement reform in North Carolina. We understand that there is a lot going on and that timely information is critical to our success. We will continue to provide these updates each quarter. In addition, we urge you to carefully review the other information that we publish regularly through Medicaid Bulletins, DMHDDSAS Communications Bulletins and other routine correspondence.

cc: Carmen Hooker Odom
Lanier Cansler
Members, Legislative Oversight Commission on MH/DD/SA
Laketha Miller
Sandra Trivett
DMHDDSAS Executive Leadership Team
Dr. Nancy Henley
Mark Benton
DMA Assistant Directors
Carol Duncan Clayton
Patrice Roesler
Jim Klingler
Wayne Williams
DMHDDSAS Provider and Advocacy Organizations